STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
			B. WIN			07/27/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF P	PROVIDER OR SUPPLIER	8		l	ORNE AVE		
BENNET	T HOUSE				LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
		r a Post Survey Revisit	R(0000			
	` ′	R completed on 5/4/2011,					
	to the Investigati	ion of Complaint					
	IN00088045 con	npleted on 3/28/2011.					
	Complaint IN00	088045 -Corrected.					
	_						
	Unrelated deficie	encies cited.					
	Survey date: July 27, 2011						
		,					
	Facility number:	004442					
	Provider number	:: 004442					
	AIM number: N						
	111111111111111111111111111111111111111						
	Survey team:						
	Gloria J. Reisert.	MSW					
	Gioria J. Reisert,	, 1115 **					
	Census bed type:						
	Residential: 34	-					
	Total: 34						
	101. 34						
	Census payor typ	n a:					
	Other: 34	ρς.					
	Total: 34						
	G1 07						
	Sample: 05						
	Those State Desi	dontial Findings one sited					
		dential Findings are cited					
	in accordance wi	th 410 IAC 16.2					
		1 . 1 . 7 . 20					
	Quality review c	ompleted on July 29,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6UT013

Facility ID:

004442

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		B. WING			07/27/2011		
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE (VO. 10. SUMMARY STATEMENT OF DEFICIENCIES				3928 H	ADDRESS, CITY, STATE, ZIP CODE ORNE AVE LBANY, IN47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2011 by Bev Fa	ulkner, RN					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6UT013

Facility ID: 004442

If continuation sheet

Page 2 of 16

CENTERSTOR	CMEDICARE & MEDIC	AID SERVICES			0111	B 110. 0750-0571
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED	
			A. BUILDING		07/27/2	n11
			B. WING		0172172	.011
NAME OF E	PROVIDER OR SUPPLIER	•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOI I EIEF		3928 ⊦	IORNE AVE		
BENNET	T HOUSE		NEW A	ALBANY, IN47150		
OVA) ID	CLD O () DV (TATE OF DEPLOYED OF				975
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
R0121	(f) A health screer	n shall be required for each				
	employee of a fac	ility prior to resident contact.				
	The screen shall include a tuberculin skin test,					
	using the Mantoux	method (5 TU, PPD),				
		ly positive reaction can be				
	•	result shall be recorded in				
		ration with the date given,				
		whom administered. The				
	facility must assur					
		employment, or within one				
	(1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test					
	· ·	r to the employee starting				
		are workers who have not				
		d negative tuberculin skin				
	_	the preceding twelve (12)				
		ine tuberculin skin testing				
		two-step method. If the first				
		second test should be				
		to three (3) weeks after the				
	first step. The free	juency of repeat testing will				
	depend on the risl	k of infection with				
	tuberculosis.					
	(2) All employees	who have a positive				
	reaction to the ski	n test shall be required to				
	have a chest x-ray	and other physical and				
	laboratory examin	ations in order to complete				
	a diagnosis.	·				
		all maintain a health record				
		that includes reports of all				
		ed health screenings.				
		with symptoms or signs of				
		ymptoms suggestive of				
		s, including, but not limited				
		ight sweats, and weight				
loss) shall not be permitted to work until tuberculosis is ruled out.						
			D0121	Submission of this response	and	00/05/2011
		review and interview, the	R0121	•		09/05/2011
	facility failed to	ensure a health screen		Plan of Correction is NOT a	i c yai	

admission that a deficiency exists

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3928 HORNE AVE BENNETT HOUSE NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE was obtained at the time of employment or, that this Statement of Deficiencies was correctly cited. or within one (1) month or tuberculin test and is also NOT to be construed were completed for 3 of 5 new employees as an admission against interest (E # 1, 2, and 3) in the sample of 5 new by the residence, or any employee files reviewed. employees, agents, or other individuals who drafted or may be discussed in the response or Plan Findings include: of Correction. In addition, preparation and submission of Review of the employee files on 7/27/11 this Plan of Correction does NOT constitute an admission or at 3:30 p.m., of new hires between agreement of any kind by the 6/16/2011 and 7/27/2011, the following facility of the truth of any facts was noted: alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1. E #1 [Employee] was hired on R 121 7/3/2011 as an LPN [Licensed Practical 410 IAC 16.2-5-1.4 (f) (1-4) Nurse]. Documentation was lacking of a Personnel health screen having been completed prior What corrective action(s) will be accomplished for those to employment. residents found to have been affected by this deficient 2. E #2 was hired on 7/12/2011 as a practice? No residents were Certified Nursing Assistant [CNA]. found to be affected. Employee Documentation was lacking of a health #1, #2, and #3 had a health screen completed on 8-4-2011. screen having been completed prior to Employee #2 had a tuberculin employment. Review of the employee file skin test administered by a indicated the employee had received a licensed registered nurse. second step PPD at her prior employment Employee #1, #2, #3, and #4 had their corresponding job which had been read 7/21/2010. There descriptions reviewed, signed, was no documentation of current TB test. and placed within their files. Employees #1, #2, #3, and #4 During an interview with the Wellness received re-education as to our Director at 4:40 p.m., he indicated that abuse policy and procedure. How the facility will identify other although the employee was scheduled to residents having the potential work, she would be taken off the schedule to be affected by the same until her health screen and annual TB test

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITH	DDIC	00	COMPLETED	
			A. BUII			07/27/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
NAME OF I	PROVIDER OR SUPPLIE	R		l			
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BENNET	T HOUSE			NEW AL	_BANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	were completed	as one had not been			deficient practice and what		
	performed.				corrective action will be take	cen?	
	performed.				No other residents were four	nd to	
					be affected. Employee files v	vere	
		d on 6/24/2011 as a CNA.			reviewed and findings were		
	Documentation ¹	was lacking of a health			corrected via our policy and		
	screen having be	een completed prior to			procedure by the Residence		
	employment.				Director and Wellness Direct		
					What measures will be put	into	
	Review of the as-worked nursing schedule				place or what systemic	_	
					changes will the facility ma		
	between 6/24/2011 and 7/26/2011,				to ensure that the deficient		
	indicated these employees had worked				practice does not recur? The		
	and had resident contact since date of				Residence Director and Well		
	hire.				Director were re-educated as our policy and procedure	s 10	
					regarding employee health		
	D	141. 41 337.11			screen, signed job description	ins	
	1	view with the Wellness			Mantoux skin testing, and ab		
		7/2011 at 4:30 p.m., he			continuing education for staf		
	indicated that te	chnically the			Going forward staff will recei		
	Administrator w	as the one responsible for			health screening and be give		
		items were in the			PPD with verification of		
	_	onnel files, but guessed			administration prior to reside	nt	
		e also, especially for the			contact. How will the correct		
		. 1			action(s) will be monitored		
		d QMAs [Qualified			ensure the deficient praction		
	Medication Assi	stant].			will not recur, i.e., what qua	-	
					assurance program will be	put	
	During an interv	view with the Wellness			into place? The Residence		
	~	7/2011 at 5:20 p.m., he			Director will perform a rando		
		ught the physicals were in			monthly review of employee for a period of four months to		
					ensure completion of health	,	
	the files as he saw some of them, but after				screening, employee Mantou	ıx	
	checking the files, he indicated he did not know why they were not there.				skin testing, abuse training, a		
					signed job descriptions. A re		
					of the results will be conduct		
					during Bennett House's QA		
					program at the end of the fou	urth	
					month. Findings suggestive	of	
	i		1	ı		,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 07/27/2011		1
	PROVIDER OR SUPPLIER		3928 H	ADDRESS, CITY, STATE, ZIP CODE ORNE AVE LBANY, IN47150	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PERCEDED BY FULL STORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0123	(h) The facility sha accurate personnel recinclude the followin (1) The name and (2) Social Security (3) Date of beginn (4) Past employme education, if applic (5) Professional lic number or dining a of completion, if applic (6) Position in the (7) Documentation including residents job skills. (8) Signed acknown residents' rights. (9) Performance ewith facility policy. (10) Date and reast Based on record facility failed to records for 4 of 5 reviewed in that training were lace employee files read the control of	all maintain current and el records for all employees. ords for all employees shall ng: address of the employee. address of the employee. anumber. ing employment. ent, experience, and cable. censure or registration assistant certificate or letter oplicable. facility and job description. a of orientation to the facility, s' rights, and to the specific elegement of orientation to valuations in accordance son for separation. review and interview, the maintain personnel of new employee records job description and abuse king in a sample of 5 new eviewed. (E #1, 2, 3, and	R0123	Submission of this response Plan of Correction is NOT a admission that a deficiency or, that this Statement of Deficiencies was correctly cand is also NOT to be const as an admission against into by the residence, or any employees, agents, or other individuals who drafted or midicussed in the response of Correction. In addition, preparation and submission this Plan of Correction does constitute an admission or agreement of any kind by the facility of the truth of any facility of the correctness of conclusions set forth in this	e and legal exists lited, rued erest lay be or Plan of NOT le exists

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 07/27/ 2	LETED	
	PROVIDER OR SUPPLIE	!	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	S SHOULD BE COMPLETION E APPROPRIATE		
TAG	1. E #1 [Employ as an LPN [Lice Documentation description and hire. 2. E #2 was hire [Certified Nursin Documentation description and hire. 3. E #3 was hire [Certified Nursin Documentation description and hire. 4. E #4 was hire a CNA but subse Activity Director lacking of a job and Activity Director lacking of him Review of the as between 6/24/20 indicated these and had resident hire. During an interv	was lacking of a job abuse training at time of d on 6/24/2011 as a CNA ng Assistant]. was lacking of a job abuse training at time of d on 7/6/2011 initially as equently became the r. Documentation was description for the CNA ector positions and of the g received abuse training	TAG	allegation by the survey R 123 410 IAC 16.2-5-1.4 (h) (1-Personnel What corrective actions be accomplished for the residents found to have affected by this deficie practice? No residents found to be affected. Em#1, #2, #3, and #4 had a screen completed and a training completed by the Wellness Director. How facility will identify other residents having the potobe affected by the sadeficient practice and corrective action will be No other residents were be affected. Employee fireviewed and findings we corrected via our policy procedure by the Reside Director and Wellness D. What measures will be place or what systemic changes will the facility to ensure that the deficient practice does not recurred to the residence Director and Director were re-educated our policy and procedure regarding employee heads screen, signed job described by the verification of administration prior to read a survey of the	agency. (s) will ose e been nt were apployee a health buse e the er otential ame what e taken? found to ales were ere and ence are put into found to ales were ere and ence are the eight ence of the found to ales were ere and ence of the eight ence of the wellness end as to each at the eight ence of the wellness end as to each at the eight ence of the	DATE	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2011	
			B. WING	A DDDEGG CITY OTHER ZID CORE	0//2//2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ORNE AVE	
BENNET	T HOUSE			LBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
1710	indicated that tec		in is	contact. How will the corre	5.112
		as the one responsible for		action(s) will be monitored	l to
making sure all items were in the				ensure the deficient practi	
employees' personnel files but guessed that he should be also, especially for the			will not recur, i.e., what qu assurance program will be	- I	
		also, especially for the		into place? The Residence	put
	LPNs, CNAs and	l QMAs [Qualified		Director will perform a rando	I
	Medication Assis	stant].		monthly review of employee for a period of four months t	
				ensure completion of health	
				screening, employee Manto	ux
				skin testing, abuse training, signed job descriptions. A re	• • • • • • • • • • • • • • • • • • •
				of the results will be conduct	
				during Bennett House's QA	
				program at the end f the fou month. Findings suggestive	
				compliance will result in ces	
				of our monitoring plan.	
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to				
	admission and shall be updated at least				
	semiannually and	upon a known substantial			
	change in the resident 's condition, or more often at the resident 's or facility 's request. A licensed nurse shall evaluate the nursing				
	needs of the reside	ent.			
		review and interview, the	R0214	Submission of this response Plan of Correction is NOT a	***************************************
	-	ensure a pre-admission		admission that a deficiency	<u> </u>
	assessment was i	•		or, that this Statement of	
		of 4 residents reviewed		Deficiencies was correctly c and is also NOT to be const	
		ssion in a sample of 5.		as an admission against into	
	(Resident #1, 3, 4	+, 3)		by the residence, or any	
	Finding included			employees, agents, or other	
	Finding included:			individuals who drafted or m discussed in the response of	· I
	1. Review of the	clinical record for		of Correction. In addition,	
		on 7/27/2011 at 2:20		preparation and submission this Plan of Correction does	
		ne resident was admitted		constitute an admission or	INO I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3928 HORNE AVE BENNETT HOUSE NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE agreement of any kind by the to the facility on 7/25/2011 and had facility of the truth of any facts diagnoses which included, but were not alleged or the correctness of any limited to, hypertension, status post conclusions set forth in this cerebular stroke, history of prostate allegation by the survey agency. What corrective cancer, pacemaker placement and action(s) will be accomplished ischemic cardiomegaly. Documentation for those residents found to was lacking of a pre-admission have been affected by this assessment by a licensed nurse to deficient practice? No residents establish a baseline for further evaluations were found to be affected. Resident's #1, #3, #4, and #5 and changes in condition. were reviewed and assessed by the licensed Wellness Director in 2. Review of the clinical record for R #3 accordance with our policy and on 7/27/2011 at 2:00 p.m., indicated the procedure. Potential residents resident was admitted to the facility on may be assessed by the house trifecta team as indicated within 6/28/2011 and had diagnoses which our policy and procedure. included, but were not limited to, diabetes Residents who trigger nurse mellitus, chronic ischemic heart disease, alerts will be communicated to the senile dementia, post operative anemia, licensed nurse prior to admission for clinical oversight. The pre and history of colon cancer. admission service level Documentation was lacking of a assessment and subsequent pre-admission assessment by a licensed assessments may be completed nurse to establish a baseline for further by the sales manager, Residence Director, and/or Wellness Director evaluations and changes in condition. prior to admission. The Wellness Director and/or licensed nurse will 3. Review of the clinical record for R #4 complete a Nursing on 7/27/2011 at 12:45 p.m., indicated the Comprehensive Assessment within 7 days of move in as resident was admitted to the facility on indicated within our policy and 7/7/2011 and had diagnoses which procedure. R 214 410 IAC included, but were not limited to, 16.2-5-2 (a) Evaluation gastrointestinal bleed, non-Hodgkin's We respectfully request a paper review of citation #3 via the IDR lymphoma, diabetes mellitus, seizures, process based on attached and atrial fibrillation. Documentation was information. How the facility will lacking of a pre-admission assessment by identify other residents having a licensed nurse to establish a baseline for

Facility ID:

l	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/27/2011
	PROVIDER OR SUPPLIER	!	3928 H	ADDRESS, CITY, STATE, ZIP CODE ORNE AVE LBANY, IN47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	further evaluation condition. 4. Review of the on 7/27/2011 at resident was adm 6/27/2011 and he included, but we hypertension, hy osteoporosis. Do of a pre-admissible licensed nurse to further evaluation condition. During an interval Director on 7/27 indicated he did assessments of the coming into the know it was need the marketing dipreliminary interther evaluation the residents price.	reclinical record for R #5 2:50 p.m., indicated the nitted to the facility on ad diagnoses which are not limited to, rpothyroidism, and becumentation was lacking on assessment by a pestablish a baseline for one and changes in set with the Wellness /2011 at 3:15 p.m., he not do any pre-admission the residents prior to them facility as he did not essary. He indicated that		the potential to be affected the same deficient practic what corrective action will taken? No other residents we found to be affected. The Wellness Director reviewed resident chart and impleme spreadsheet to ensure time of completion of the Nursing Comprehensive Assessment indicated within our policy a procedure. What measure be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur? The Wellness Director Residence Director, and Sa Manager was re-educated policy and procedure regard the Service Level Assessment and Negotiated Service Platalong with the Nursing Comprehensive Assessment Wellness Director will review resident charts and docume a newly implemented spreadsheet to ensure completion of the Nursing Comprehensive Assessment indicated within our policy a procedure. How will the corrective action(s) will be monitored to ensure the deficient practice will not i.e., what quality assurance program will be put into place? The Wellness Direct upon hire had developed an implemented a spreadsheet ensure semi annual evaluation.	e and be vere Inted a liness gent as and es will Int the tor, ales to our ding ent ent ent via Interest of the ent via

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
			A. BUILDING B. WING			07/27/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					were completed as indicated within our policy and procedu. The Wellness Director upon has conducted a QA of curre residents and completed an updated re-assessment of residents utilizing our assess tools per our policy. The Wel Director is currently performi ongoing monthly review of residents utilizing a spreadsh she developed and impleme to ensure our assessment to and completed per our policy. Potential residents may be assessed by the house trifecteam as indicated within our policy and procedure. Reside who trigger nurse alerts on the service level assessment will communicated to the license nurse prior to admission for clinical oversight and intervent.	ure. hire ent sment llness ng an neet nted ols /. eta ents ne I be	
R0216	shall be delineated manual, but at a massessment shall following: (1) The resident 's mental status. (2) The resident 's activities of daily li (3) The resident 's and semiannually (4) If applicable, the self-administer medical to the control of the evaluation writing and kept in Based on record	s weight taken on admission thereafter. he resident 's ability to edications. shall be documented in	RO)216	Submission of this response Plan of Correction is NOT a admission that a deficiency of	legal	09/05/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6UT013

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004442

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3928 HORNE AVE BENNETT HOUSE NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE self administration of medication to or, that this Statement of Deficiencies was correctly cited. administer insulin was done on 1 of 1 and is also NOT to be construed resident (R #4) in a sample of 5 residents as an admission against interest reviewed for self administration of by the residence, or any employees, agents, or other medications. individuals who drafted or may be discussed in the response or Plan Finding includes: of Correction. In addition, preparation and submission of Review of the clinical record for Resident this Plan of Correction does NOT #4 [R] on 7/27/2011 at 12:45 p.m., constitute an admission or agreement of any kind by the indicated the resident was admitted to the facility of the truth of any facts facility on 7/7/2011 and had diagnoses alleged or the correctness of any which included, but were not limited to, conclusions set forth in this allegation by the survey agency. R diabetes mellitus, seizures and 216 410 IAC 16.2-5-2 (c) (1-4) (d) non-Hodgkin's lymphoma. **Evaluation We respectfully** request a paper review of Review of the 7/7/2011 "Appendix B citation #4 via the IDR process Service Assessment/Negotiated Service based on attached information. Plan", the evaluation indicated the What corrective action(s) will be accomplished for those resident needed the facility to manage all residents found to have been aspects of the resident's routine insulin affected by this deficient administration, including safe disposal of practice? No residents were all sharps. found to be affected. Resident #4 was assessed by the prior Wellness Director with On 7/20/2011, new physician orders were documented evidence of received which indicated the resident was assessment located and faxed okay to self-administer his own insulin onto you for reconsideration. and for Lantus [an insulin] 14 units every Resident #4 was re-assessed by the Wellness Director as to morning. his/her ability to safely manage his insulin as indicated within the Documentation was lacking of an physician's order. The Wellness assessment having been completed by Director re-assessed this residents ability to safely store nursing to evaluate the resident to be sure and administer insulin utilizing the he was capable and safe to administer his

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: BENNETT HOUSE INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE AVE NEW ALBANY, INVT150 INTELL ADDRESS, CITY, STATE, APPCODE 3928 HORNE 3	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
R0356	(i) A current emerge be immediately act in case of emerge following: (1) The resident 's apartment number date of birth. (2) The resident 's (3) The name and legally authorized (4) The name and resident 's physic (5) The name and family members of contacted in the edeath. (6) Information on (7) A photograph (resident). (8) Copy of advantaged on record facility failed to files contained a newly admitted reviewed in a residents. Findings include 1. Review of the emergency file b	phone number of the an of record. telephone number of the other persons to be vent of an emergency or any known allergies. for identification of the ce directives, if available. review and interview, the ensure the emergency picture to identify 3 of 4 esidents (R# 3, 4, and 5) idential sample of 5	R0356	medication through interview implementation of the newly developed spreadsheet indice periodic reviews as quarterly when deemed necessary. Submission of this response Plan of Correction is NOT a admission that a deficiency or, that this Statement of Deficiencies was correctly cand is also NOT to be constructed as an admission against interpretation of the residence, or any employees, agents, or other individuals who drafted or madiscussed in the response of Correction. In addition, preparation and submission this Plan of Correction does	e and cating y or e and legal exists sited, rued erest expense of ay be r Plan of		
	resident was adm	2:00 p.m., indicated the nitted to the facility on mentation was lacking of		constitute an admission or agreement of any kind by the facility of the truth of any fac	e		

004442

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU OO COMPLE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	1	
			B. WIN			07/27/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
			3928 HORNE AVE				
BENNE	T HOUSE			NEW AI	LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 ^	resident in the emergency			alleged or the correctness of	any	
	file book in orde	er to identify the resident			conclusions set forth in this allegation by the survey age	nev P	
	in case of an em	ergency.			356 410 IAC 16.2-5-8.1 (i) (1	-	
					Clinical Records What	0,	
	2. Review of the	clinical record and			corrective action(s) will be		
	emergency file h	oook for R #4 on			accomplished for those		
	1 '				residents found to have be	en	
	7/27/2011 at 12:45 p.m., indicated the resident was admitted to the facility on				affected by this deficient		
					practice? No residents were		
	7/7/2011. Documentation was lacking of				found to be affected. Reside		
	a picture of the resident in the emergency				#4, and #5 had emergency f information updated to include		
	file book in order to identify the resident				following information as indic		
	in case of an emergency.				with Indiana state ruling R 3		
					410 IAC 16.2-5-8.1 (i) (1-8)		
	3. Review of the	clinical record for R #5			Clinical Records: (1) The res	sident'	
	on 7/27/2011 ind	dicated the resident was			s name, sex, room or apartn		
	admitted to the f	Facility on 6/27/2011.			phone number, age, or date		
		was lacking of a picture			birth. (2) The resident's hosp		
	1	the emergency file book			preference. (3) The name ar phone number of any legally		
	1	ify the resident in case of			authorized representative. (4		
		ify the resident in case of			name and phone number of		
	an emergency.				resident's physician of record	d. (5)	
	l				The name and telephone nu		
	1 -	riew with the Wellness			of the family members or oth		
	1	IA #1 [Qualified			persons to be contracted in t		
	Medication Assi	stant] on 7/27/2011 at			event of an emergency or de (6) Information on any know		
	3:25 p.m., they i	ndicated emergency file			allergies. (7) A photograph (
	pictures were tal	ken and placed into the			identification of the resident.		
	1 ~	n of the emergency file			Copy of advanced Directives	` '	
	1	. They indicated they were			available. How the facility w		
	1 -	s time which explained			identify other residents have	_	
	1	residents had them and			the potential to be affected	-	
	1 -	nat a picture was only			the same deficient practice what corrective action will		
	1	-			taken? The Wellness Direct		
	1 ^	edication book but not the			reviewed the resident emerg		
	1 '	book like it was supposed			file to ensure continued	,	
	to be. They also	indicated the emergency					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING		COMPLETED 07/27/2011	
	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	3928 H	ADDRESS, CITY, STATE, ZIP CODE ORNE AVE LBANY, IN47150 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEPICIENCY)	(X5) COMPLETION
	file book was the contained the em service plans and the book they wo	eir care guide which hergency file information, I nursing notes and was he medication book.		compliance with Indiana staruling R 356 410 IAC 16.2- (i) (1-8) Clinical Records. Findings were identified an corrected through our QA process. What measures be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur? The Wellness Director was re-educated to Indiana stat ruling R 356 410 IAC 16.2- (i) (1-8) Clinical Records. The Wellness Director will be responsible for periodic revithe emergency file to ensure continued compliance with above mentioned information the will the corrective action(s) will be monitore ensure the deficient pract will not recur, i.e., what quassurance program will be into place? The Wellness Director will perform a rand monthly review of the emplemergency file for a period (6) months. Findings will be reviewed within six months the plan regarding continue frequency of monitoring. Fi suggestive of compliance with criteria for cessation our monitoring plan.	ate 5-8.1 d will at the ot etor essessive essessive estable on. d to ice cuality e put essessive esses e